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Report of the 2015 Social Forum (Geneva, 18–20 February 2015)*

Chairperson-Rapporteur: Faisal bin Abdulla al-Henzab (Qatar)

Summary

The present report contains a summary of discussions and recommendations of the 2015 Social Forum. In accordance with Human Rights Council resolution 26/28, the Forum was held in Geneva from 18 to 20 February 2015, and focused on access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including best practices in that regard.

* The annexes to the present report are circulated as received.

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I. Introduction

1. The Human Rights Council, in its resolution 6/13, preserved the Social Forum as a unique space for interactive dialogue between the United Nations human rights machinery and a variety of relevant stakeholders, underlining the importance of coordinated efforts at the national, regional and international levels for the promotion of social cohesion based on the principles of social justice, equity and solidarity; to address the social dimension and challenges of globalization; and issues linked with the national and international environment required for the promotion of the enjoyment of all human rights by all.[1]

2. In accordance with Human Rights Council resolution 26/28, the Social Forum was held in Geneva from 18 to 20 February 2015 and considered access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including best practices in that regard. The President of the Council appointed Faisal bin Abdulla al-Henzab, Ambassador and Permanent Representative of Qatar to the United Nations Office at Geneva, as the Chairperson-Rapporteur of the Forum.

3. The programme of work[2] was prepared under the guidance of the Chairperson, with inputs from relevant stakeholders. Pursuant to Human Rights Council resolution 26/28, paragraph 8, background reports made available by the Office of the United Nations High Commissioner for Human Rights (OHCHR) informed the discussions (A/HRC/23/42, A/HRC/17/43 and A/HRC/11/12). The present report contains a summary of the proceedings as well as conclusions and recommendations.

II. Opening of the Social Forum

4. In his opening remarks, the Chairperson-Rapporteur of the Social Forum called on participants to identify and promote concrete, progressive and action-oriented approaches to improve access to medicines. Noting the particular significance of that issue to the State and people of Qatar, he advocated greater international cooperation to guarantee access to medicines, which was critical for health, well-being and development for all and a matter of social justice. Therefore inequities, including high costs borne by patients in many low and middle-income countries, must be eliminated. To that end, the international community should support innovation and local production, use of flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), policy coherence among human rights obligations and international trade and investment regimes, and active engagement of all stakeholders, including the private sector, to save the lives of millions who do not have access to medicines.

5. Jane Connors, Director of the Research and Right to Development Division, OHCHR, described access to medicines as a critical and timely issue, particularly in the light of the emerging post-2015 development agenda. OHCHR had consistently advocated that the agenda be underpinned by human rights law, which obliged States to respect, protect and fulfil the right to health. The International Covenant on Economic, Social and Cultural Rights required States to take steps, to the maximum of their available resources, towards realization of the right to health, prohibited retrogressive measures, and required immediate fulfilment of minimum core obligations. According to the Committee on

[1] For further details on the Social Forum, see www.ohchr.org/EN/issues/poverty/sforum/pages/sforumindex.aspx.

[2] Available from www.ohchr.org/Documents/Issues/SForum/SForum2015/PoW.pdf.

Economic, Social and Cultural Rights, access to medicines was a core obligation. Medicines must be affordable, acceptable, accessible, of good quality, and made available without discrimination. Yet, 2 billion men, women and children had no access to essential medicines. Ms. Connors called on the international community to take immediate steps to rectify that tragedy, including by building production capacity in developing countries, allowing access to generic drugs and enhancing research and development relating to treatment for neglected diseases.

6. Joachim Rücker, President of the Human Rights Council, affirmed his support for the Social Forum as a subsidiary body of the Council, bringing together multiple stakeholders including Member States, civil society and others. The Forum provided a unique space enabling constructive engagement to discuss practical solutions to real life problems including at the grass-roots level. He called for immediate action to strengthen health systems, establish universal health coverage and ensure access to safe and efficacious medicines. Recent tragedies, like the Ebola outbreak in West Africa, illustrated the need for immediate measures to strengthen health systems with rights-based solutions that affirmed peoples' dignity and ensured their well-being. In moving forward, including on access to medicines in the post-2015 development agenda, respect for human rights must be the ultimate foundation upon which rested the legitimacy of the actions of governments, international institutions and corporations.

III. Summary of proceedings[5]

A. Keynote speakers and general statements

7. Deqo Mohamed, Chief Executive Officer of the Dr. Hawa Abdi Foundation in Somalia, described its work. With limited resources, it had provided health care to over a million people in a war-torn, rural setting. She advocated a holistic approach to health-care delivery by improving access to clinics (roads and infrastructure), training medical personnel and building health facilities. The Foundation also developed the skills of grass-roots communities. The Hawa Abdi Village that had grown around the clinic represented a bastion of security and community. While international non-governmental organizations contributed to programmes, their roles were often temporary, leaving a vacuum following their departure. Support was required to establish a functioning public health system, including through training community health workers and improved use of technology. Mobile phones, for example, could facilitate communication between patients and health personnel, where physical access was difficult. A renewed focus on sustaining access to medicines was needed, including by empowering people through education designed to promote their independence.

8. Jorge Bermudez, Vice-President of Health Production and Innovation, Fundação Oswaldo Cruz, Ministry of Health, Brazil, discussed the impact of international trade agreements on access to medicines and the need to integrate right to health considerations in negotiations. The TRIPS Agreement should not impede the realization of the right to health. In its negotiations, Brazil advocated measures to uphold the right to health. It had explicitly embraced that right in its domestic laws and policies, including by guaranteeing universal access to health care and linking health and development. Brazil had used public-private partnerships to reduce medicine costs and develop local expertise. It had also employed price regulation, essential medicines lists and other domestic policies. Those

[5] Statements and presentations made available to the Secretariat are available from www.ohchr.org/EN/Issues/Poverty/SForum/Pages/StatementSForum2015.aspx.

efforts had resulted in substantially lower prices for antiretroviral therapies. Nevertheless, affordability remained a major problem. He called for national, regional and global action to address the human rights implications of the intellectual property regime, including expansion of TRIPS flexibilities, increased use of voluntary licensing mechanisms and international support to promote progress towards trade agreements that improved access.

9. Stephen Lewis, Co-Director of AIDS-Free World, discussed affordability and the responsibilities of pharmaceutical companies. He decried a system that allowed companies to charge tens of thousands of dollars for treatment with a production cost of only around 100 dollars, wherein companies intensively lobbied governments to protect the status quo. Emphatic that balance sheets must not be prioritized over human lives, Mr. Lewis recalled the recommendation of the Global Commission on HIV and the Law to convene a neutral high-level body to develop a new intellectual property regime for pharmaceutical products, and to place a moratorium on patent protection of medicines in future free-trade agreements. He proposed five steps to increase access to medicines: (a) use the proposed sustainable development goals, especially goal 3.8, to put pressure on governments; (b) litigate against pharmaceutical companies; (c) integrate right to health considerations in trade negotiations; (d) form alliances to raise awareness of cost and accessibility issues; (e) support OHCHR in its efforts to encourage governments to fund health care.

10. In the general statements segment, representatives of Brazil, Chile, China, Colombia, Cuba, India, Pakistan, South Africa, Sri Lanka, Thailand, the Bolivarian Republic of Venezuela, the Holy See, the Ariel Foundation International and Autistic Minority International intervened. States highlighted measures at the national level for ensuring access to medicines. They emphasized that health concerns must prevail over intellectual property rights and commercial interests and called for flexibility in the TRIPS Agreement. Other issues raised included: quality of medicines; production of generics; supporting local capacity; inequality between States and the resulting impact on access; mental health; overprescription; international cooperation; public-private partnerships; benefits of healthy populations to development; links between health costs and poverty; investment and innovation; mobilizing resources to combat disease in developing countries; medication for children; youth participation in relevant discussions; black markets; health-care laws and policies.

B. Overview of access to medicines in the context of the right to health

11. Martin Khor, Executive Director of the South Centre, described access to medicines as a cornerstone of the enjoyment of the rights to health and life. Key barriers included investment treaties and regional agreements limiting TRIPS flexibilities, reduced government revenues owing to economic situations, and conditions that prevented the establishment and continued functioning of generic companies. To address those challenges, he suggested: (a) promoting the use of TRIPS flexibilities; (b) renewing TRIPS exceptions for least developed countries for as long as they retained that status; (c) permitting TRIPS exceptions for middle-income countries; (d) amending investment treaties that threatened the right to health; (e) eliminating TRIPS-plus provisions and other clauses in free-trade agreements that might jeopardize access to medicines and the right to health; (f) protecting public health services even in times of economic crisis; (g) building capacity to produce generic medicines; (h) promoting universal access to newly developed medicines; (i) prioritizing development of medicines for drug-resistant diseases; (j) promoting publicly funded and shared research and development; (k) providing financial and technological assistance to developing countries.

12. Zafar Mirza, Coordinator, Public Health, Innovation and Intellectual Property, Department of Essential Medicines and Health Products, World Health Organization

(WHO), presented an overview of the WHO work on access to medicines which was one of its six leadership priorities. Access to medicines could be rendered sustainable in the context of universal health coverage and functioning health systems. It was an unequivocal part of the human right to health and a complex issue involving multiple stakeholders, determinants and perspectives. WHO strived to promote universal access to safe, effective and high quality medicines that were prescribed and used rationally, and monitored by appropriate regulatory mechanisms. Access to existing medicines (generic and patent) should be improved and research and development for new essential medicines should focus on improving health outcomes, not only returns on investment. The medical needs of the most vulnerable must be met. Litigation on the right to health promoted access to medicines.

13. Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, denounced widespread and crippling inequalities in access to health services and medicines that had left 2 billion people without access to the health products they needed. Ill health was both a cause and consequence of poverty and access to medicines was a particularly pertinent problem in the developing world. States must ensure that medicines were affordable and accessible on a non-discriminatory basis. That required improved procurement and distribution globally, especially in developing countries. Research and development in medicines for neglected diseases must be improved. Although States had the primary responsibility for ensuring access to medicines, including through domestic health policies, intellectual property laws and donor country policies could also have major impacts. He discussed problems of medicine overuse and misuse especially in relation to mental illness. Prescription of medicines, particularly psychotropic medicines, should be part of a holistic approach to treatment.

14. During the interactive dialogue, representatives of India, the Indian Council of South America, the International Association for Hospice and Palliative Care and Rencontre africaine pour la défense des droits de l'homme took the floor. The speakers highlighted issues such as lack of access to effective pain relief medicines, the slow response to the Ebola crisis, the failure of the intellectual property regime to protect traditional knowledge from exploitation by pharmaceutical companies, and differences between challenges relating to access to patented and generic drugs.

15. In response, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health observed that there were many lessons to learn from the Ebola crisis. He called for improved response systems, mobilization of additional resources, and improved health systems and infrastructure to prevent crises. Dr. Mirza clarified the fact that the challenges in access to patented and generic drugs were the same, but that the high prices of patented drugs posed an additional challenge. He suggested a broader approach going beyond a focus on patented drugs and market failures, to also recognize failures in public policy. Speaking on behalf of Mr. Khor, Germán Velásquez, Special Adviser for Health and Development at the South Centre, suggested that WHO employ article 19 of its Constitution to make binding decisions and deliver justice in access to medicines.

C. Improving health delivery systems in challenging contexts

16. Abdul Majeed Siddiqi, Head of Mission, HealthNet TPO, Afghanistan, discussed mental health treatment in fragile States. In Afghanistan, the work of HealthNet TPO since 2000 had included efforts to integrate mental health services in the health systems of 15 provinces on the basis of fact-finding, education and training, and policy advocacy. However, approximately half the Afghan population suffered from mental health problems, compared with 20 per cent in other developing countries, and only 2 per cent sought

treatment. Additional challenges in Afghanistan included: stigmatization of mental health patients; unequal integration of mental health services in primary and secondary health care; lack of quality referral health care, funding and prioritization by the Government and donors; staff capacity, supply of medicines in health facilities, quality of medicines and compliance.

17. Msgr. Robert J. Vitillo, Head, Caritas Internationalis, Geneva, while acknowledging the role of States, pointed to the complementary role in health crises of various stakeholders including faith-based organizations. Following the Ebola outbreak, while governments and international organizations struggled to respond, organizations like Caritas had acted immediately at the local, national, regional and international levels. They strengthened and maintained support provided by local Catholic health services and mobilized international volunteers, working with local communities. Faith-based organizations were particularly well placed to ensure that human dignity was upheld in all circumstances, and to provide local communities with material, pastoral and spiritual support that complemented medical support from health-service providers.

18. Mahmoud Daher, Head, WHO Gaza sub-office for the occupied Palestinian territories, explained how since 1967 military occupation had impeded development in the region, weakening all aspects of development for 4.2 million Palestinians and adversely affecting health systems. In Gaza, multiple external and internal factors had caused chronic shortages in essential medicines averaging 30 per cent over the past five years, and, averaging 50 per cent in disposable medical supplies. Unreliable fuel supplies and inadequate equipment and financial resources also posed obstacles to health services delivery, especially in Gaza. He noted that the Palestinian health sector would continue to suffer until the structural causes of those deficiencies were addressed and barriers were removed to control over resources and planning, to economic and educational opportunities and to self-determination.

19. During the interactive dialogue, interventions were made by representatives of the Congo, Associazione Comunità Papa Giovanni XXIII, the China Medical Association, Health Innovation in Practice, New Generation Ishaka, the People's Health Movement, and by Dr. Bermudez and Raffaela Schiavon, General Director, Ipas Mexico. Suggestions included: (a) the international community must guarantee access to essential drugs and protect and support health-care professionals even in challenging contexts and people in vulnerable situations including women, must have access to medicines; (b) renew the focus on direct actions to improve health systems, including in rural areas, and to train medical personnel and support staff; (c) build trust between communities and health workers; (d) effectively coordinate international responses to health challenges; (e) base long-term, sustainable approaches to improve access to medicines, on data and not politics.

20. In his concluding remarks, Msgr. Vitillo observed that maternal health care was often neglected in challenging contexts, for example, Ebola treatment units had no facilities designed for childbirth. However, increased cooperation between governments, international medical teams and non-governmental organizations working with local communities could support better health outcomes. Mr. Daher noted that many health-care professionals in Gaza had not received their salaries for over a year, causing serious strains on the system. Dr. Siddiqi stated that donors adopted different approaches, but that there had been some recent success in streamlining and improving the effectiveness of international assistance to improve access to essential medicines in challenging contexts. Panellists agreed on the need for pharmaceutical companies, governments and the international community to improve responsiveness to crises and ensure the realization of human rights.

D. Access to medicines for women and children

21. Dr. Schiavon stated that ensuring access to, and consistent procurement of, reproductive and neonatal health commodities was essential to ensuring human rights including the rights to health and life. Although maternal mortality rates had dropped significantly since 1990, 289,000 women had still died from causes relating to maternity in 2013, and there were significant disparities in mortality rates between regions. Worldwide 41 per cent of pregnancies were unwanted, and most of them were due to non-use or underuse of contraceptives. Lower contraceptive use correlated with higher rates of abortion. Reducing unintended pregnancies could avert 60 per cent of maternal deaths and 57 per cent of child deaths. Although access to contraceptives had increased, inequities remained both within and between States. Diverse challenges and barriers prevented equal access to potentially life-saving drugs for women, including ideological opposition to certain medications, such as emergency contraception and misoprostol (oral oxytocic) recommended for a variety of obstetric uses. She advocated evidence-based guidelines and policies to promote access to medicines for sexual and reproductive health.

22. Tarek Meguid, Associate Professor, State University of Zanzibar, asserted that lack of access to medicines constituted a grave human rights violation, particularly in maternal and child health. Quoting Mahmoud Fathalla, he said that women were not dying from a lack of technical capacity. They were dying because they were poor, powerless and pregnant, and the international community had yet to make the decision that their lives were worth saving. He described inadequate facilities which had an air of veterinary medicine about them, and stressed that the lives and dignity of poor women and children must be protected. Women must be given the space to empower themselves so that they can take control of their own lives. Dr. Meguid called for the creation of physical, economic and social spaces for women to give them agency and enable them to be the drivers of change. That required immediate action.

23. Lingli Zhang, Professor and Director of Pharmacy, West China Second University Hospital, Sichuan University, described efforts to improve children's access to medicines in the BRICS countries (Brazil, China, India, the Russian Federation and South Africa), noting their efforts to reach reduction targets in child mortality. While many affordable and accessible medicines had been developed, effective intervention was often inadequate owing to the lack of paediatric formulations and other factors. Despite positive steps, only 4.1 per cent of medicines in China were reserved for children, according to a survey of medicines used in paediatrics in 15 hospitals. Dr. Zhang suggested that an appeal be launched to raise global awareness of the need for all States to have an essential medicine list for children. She called for States to learn from each other's good practices, including advances by BRICS countries, like the essential medicine list for children in China, India and South Africa.

24. In the ensuing discussion, the speakers were Dr. Mohamed and representatives of OHCHR, Associazione Comunità Papa Giovanni XXIII, Autistic Minority International, the Center for Reproductive Rights and the People's Health Movement. They discussed governmental duties to ensure access to information on contraceptive services on a non-discriminatory basis; access to medicines for pregnant women living with food insecurity, and for autistic women and children; and the potential of education in reducing infant mortality. War and migration disproportionately affected women, mothers and children. In such cases, special health policies should be implemented and drugs made available in durable forms that did not require refrigeration.

25. Dr. Meguid stated that poor conditions were the standard for people who lived with inadequate medical facilities. Since they had no agency in relation to their health needs that would enable accountability, they did not complain. Health facilities were understaffed and

their personnel worked in unacceptable conditions. Health workers became both victims and perpetrators of human rights abuses. Consequently, they would continue to deliver inferior health services until they and their patients were empowered. Dr. Schiavon concluded that inequity in access to contraceptives and some other medicines was global, and often an ideological issue. Dr. Zhang called for change in mindsets on access to medicines and stressed the importance of an effective health policy.

E. Intellectual property rights and access to medicines

26. Lisa Forman, Assistant Professor, Dalla Lana School of Public Health, University of Toronto, described access to medicines as one of the most explicit examples of how economics and trade rules conflicted with human rights, including the rights to life, health and development. She focused on how intellectual property rights had an impact on drugs, illustrated by the increase in drug prices in Malaysia of 28 per cent per year between 1996 and 2005 following the implementation of TRIPS. Over 2 billion people still lacked access to essential medicines, with drug pricing remaining a key obstacle to access. She called on the United Nations to support the use of compulsory licensing as a proven means of reducing prices and realizing State duties under the right to health. States should be held to account in the universal periodic review process for imposing TRIPS-plus provisions in free trade agreements as a violation of the right to health. Ms. Forman suggested that TRIPS flexibilities were an insufficient solution to pricing concerns, referring to the Global Commission on HIV and the Law's recommendation that the Secretary-General create a new body to recommend a new intellectual property rights regime for drugs.

27. Thamara Romero, Legal Officer, Intellectual Property Unit, United Nations Conference on Trade and Development (UNCTAD) discussed UNCTAD work on access to medicines. The UNCTAD mandate in that area was based on the 2012 Doha Mandate (TD/500/Add.1, para. 65 (j)), and its assurance of the supply of essential medicines. UNCTAD had observed an increased need to diversify and expand pharmaceutical production. In the future India might no longer be considered the "pharmacy of the world". Expanding local production could result in improved access. She referred to a high court case in Peru in which an individual's right to health had been upheld, regardless of whether the Government had assigned adequate financial resources to the health sector. She called for increased use of TRIPS flexibilities. She argued that, if properly implemented, human rights and intellectual property were not necessarily contradictory. However, it was necessary to create awareness among policymakers and judges on the application of TRIPs flexibilities to enhance access to medicines.

28. Antony Taubman, Director, Intellectual Property Division, World Trade Organization (WTO), highlighted the intersection of health, trade and intellectual property rights. The Doha Declaration on the TRIPS Agreement and Public Health was a major milestone in understanding those intersections, recognizing the importance of intellectual property in the development of new medicines while acknowledging possible effects on pricing — a basis for international policy discussions seeking to implement practically an appropriate balance between promoting access and innovation. He recommended greater international cooperation to fulfil the right to health, required for sustainable development. He outlined three broad areas for future work: (a) elucidation of rules, data and industry developments; (b) coordination of operations and system-wide coherence; (c) implementation and action. Drawing on the study by WTO, the World Intellectual Property Organization and WHO, *Promoting Access to Medical Technologies and Innovation*, he noted widespread recognition of the need to strengthen national health systems and to develop innovative procurement solutions within existing legal and policy frameworks.

29. During the interactive dialogue, comments were made by representatives of Colombia, India, Mexico, the Colombian Commission of Jurists, Knowledge Ecology International, the People's Health Movement-Safe Observer International, Third World Network, Universities Allied for Essential Medicines, as well as by Dr. Bermudez, Dr. Schiavon and Regina Kamoga, Executive Director, Community Health and Information Network, Uganda. They discussed the following: South-South cooperation; patent monopolies; TRIPs-plus provisions in free trade agreements; the fundamental unfairness of intellectual property regimes, particularly for middle income countries; definition of "essential medicines"; alternatives to TRIPS; the role of WTO; contribution of universities to innovation and development of medicines; barriers to research and development; antibiotic resistance and the challenge from intellectual property regimes that hampered the supply of effective antibiotics; the positive role of TRIPs in spurring innovation; the need for more compulsory licensing in developing countries.

30. In her closing remarks, Ms. Forman referred to the responsibilities of States in ensuring access to all medicines, not only essential medicines, and asserted that the current system of TRIPs exceptions and flexibilities was inequitable. The Optional Protocol to the Convention on Economic, Social and Cultural Rights, which had entered into force on 5 May 2013, established a legally binding petitions procedure, an important mechanism for interpretation and enforcement of the right to health. Mr. Taubman reiterated the importance of policy coherence across legal and policy regimes. He called for intellectual property experts to develop a stronger understanding of public health issues, and for health practitioners and policymakers to gain a practical understanding of TRIPS flexibilities. Ms. Romero noted that different countries had different needs, but that analyses of national legal strategies were helpful in implementing the TRIPS agreement and its flexibilities. Improved local production capacity facilitated access to medicines.

F. Lessons learned and emerging challenges in the global response to AIDS

31. Martin Choo, Asia Pacific Network of People Living with HIV/AIDS (APN+), stressed the importance of equitable access and effective treatment. He asserted that access to treatment was a human right, treatment made patients feel human, and effective treatment was a public good. However, patients were being left behind, and many of those so left behind were from vulnerable social groups including the poor, sex workers, drug users and lesbian, gay, transgender, transsexual and intersex persons. He argued that patients should not be mere statistics. In the Asia Pacific region, almost 40 per cent of people infected with HIV/AIDS were not receiving treatment. Depression and mental illness were highly prevalent amongst people with HIV but they often went untreated as well. In national legislatures APN+ had strongly advocated that people living with HIV had the right to have access to treatment. APN+ also worked to extend treatment and community support to the most vulnerable.

32. Alma de Leon, Regional Director, International Treatment Preparedness Coalition, Latin America and the Caribbean, explained that many medicines available in the developed world were not available in Latin America. Children often had little access to treatment, which might, however, be reduced or eliminated when they became adults for lack of the third line of drugs, which were inaccessible in some countries because of their high price. The new development goals must accelerate universal coverage and eliminate gaps in access to medicines. Universal health care would only become a reality if the people's demands were met and if human rights prevailed over intellectual property rights. She called on the international community to break down barriers to access and pursue international trade and investment laws that permitted access to affordable medicines. The

commendable efforts of community movements in exerting pressure to reduce prices must be redoubled to enhance progress towards access to affordable medicines for all.

33. Tenu Avafia, Policy Adviser, HIV, Health and Development Practice, Bureau for Development Policy, United Nations Development Programme, cited the report of the Global Commission on HIV and the Law which called for changes in legal systems. That could prevent up to 900,000 new HIV infections by 2030. The Joint United Nations Programme on HIV/AIDS had set several targets in that regard including: halving the number of countries with punitive laws and practices around HIV transmission; creating an environment which safeguarded dignity, health and justice; and developing action-oriented, evidence-based recommendations for effective AIDS responses that promoted and protected the human rights of people living with and most vulnerable to HIV. The report emphasized that application of the current patent regime to medicines was a recent development. Furthermore, States had historically had the right to license patented inventions compulsorily when needed. The TRIPS Agreement posed a barrier to access to medicines. It benefited patent-holders at the expense of people living with HIV. The report recommended that the Secretary-General examine proposals for a new multilateral regime to promote innovation and increase access, that developed countries stop pushing TRIPS-plus agreements, that developing countries use TRIPS flexibilities, and that least developed countries be indefinitely exempted from TRIPS.

34. During the dialogue, there were interventions from representatives of the Bolivarian Republic of Venezuela, the China Medical Association, Health Innovation in Practice and Zomi Community USA, as well as from Amit Sengupta, Associate Coordinator, People's Health Movement, India, and Dr. Bermudez. They called for urgent action to change an intellectual property regime that continued to be a barrier to access to medicines. The achievements of the AIDS movement had not been adequately translated into improved access to all medicines for all. Continued activism would support access to medicines for HIV/AIDS treatment and States must act to improve their local production of drugs, eradicate stigmatization of persons living with HIV/AIDS and ensure that domestic laws and policies promoted, protected and fulfilled people's right to health.

35. In conclusion, panellists emphasized the need to eliminate stigma and discrimination against persons living with HIV/AIDS. Mr. Choo called for increased support from international organizations, improved mental health care and strategic, interlinked, community-based partnerships to support and care for persons living with HIV/AIDS. Ms. de Leon advocated increased attention to key populations and an end to senseless deaths caused by stigmatization of persons living with HIV/AIDS. Mr. Avafia stressed the importance of strong legal systems in protecting patient confidentiality and reducing stigma. He observed that current drug prices were not sustainable even in developed countries and that they affected persons suffering from all diseases. He argued for policy coherence to reconcile human rights obligations and international trade and investment laws.

G. Patient-centred approaches to access to medicines

36. Ms. Kamoga called for a people-centred approach to access to medicines that took into account cultural and demographic differences to extend appropriate and effective health care to rural and urban populations alike. Rural populations faced particular difficulties in reaching medical centres and were more likely to experience lack of access to medicines owing to shortages. She explained that Uganda had both formal and informal medical systems. People who lacked access to formal systems must rely on private health care and pay three to five times more for medicines than those with formal coverage. Innovative approaches were essential to ensure access to medicines and save lives. Civil

society organizations had led the way by extending medical services to rural areas, promoting community drug distribution programmes that pooled transportation costs and providing social support and education for patients. Unfortunately, many national governments in developing countries lacked the political will to take action to protect their citizens. They must act immediately to ensure access to affordable, high quality and safe medicines and promote further investment in research and development.

37. Dimitry Borisov, Executive Director, Equal Right to Life, Russian Federation, asserted that all persons had an equal right to life. Therefore, access to medical care for all categories of patients must be ensured. Unfortunately, in the Russian Federation, there were plans to reduce spending on health care from 3.6 per cent to 2.8 per cent of gross domestic product, placing a direct threat to access to medicines. Beyond resources, there were structural barriers to access including inadequate transparency in decision-making processes, insufficient collection of data, and a gap between legislative policies and their financing and execution. Those problems were clearly evident in cancer treatment. The inadequate treatment of cancer patients substantially affected mortality rates and those problems were reflective of the health system of the Russian Federation as a whole. Equal Right to Life promoted a patient-centred approach and advocated fulfilment of State health-care commitments and intersectoral collaboration.

38. Noel Hayman, Clinical Director, Inala Indigenous Health Service, Australia, described his efforts to extend health care to aboriginal communities, in which life expectancy was 17 years less than for other Australians. He emphasized the importance of quality research and good data to ascertain the origins of health outcome disparities. Research revealed that few indigenous peoples had access to and used primary health-care systems. Results of a focus group demonstrated that many aboriginal Australians were not accessing available health services because of cultural differences making them feel unwelcome. By actions to bridge those cultural differences, including employment of aboriginals in health systems, cultural awareness strategies and educational outreach, the health service had greatly expanded its reach. The key was to understand and acknowledge the culture and community. To further close the health coverage gap for indigenous peoples, the private sector, national and local governments, medical practitioners and communities must continue to collaborate to address their specific medical needs effectively. By so doing, the health service had improved access to affordable medicines.

39. Dr. Sengupta stated that people working together had the power to change health systems by demanding fulfilment of their rights. In India, there was a history of common people uniting to bring about transformative change. Access to medicines had always been an issue for popular mobilization by the masses. Civil society organizations in India campaigned against large pharmaceutical companies and put pressure on the Government to introduce measures that would allow generic pharmaceutical and local production to thrive. Consequently, drug prices in India were 10 per cent or less than global prices, and Indian generics helped reduce the cost of antiretrovirals by more than 40 times. However, the implementation of TRIPS in India posed a threat both for India and importing States. He called for global solidarity and collective action to address that threat, preserve the generic industry of India, resist pressure to adopt TRIPS-plus agreements and improve access to medicines for all.

40. During the interactive dialogue, there were interventions from Dr. Mohamed and Dr. Schiavon, representatives of Panama, the United States of America, WHO, the International Association for Hospice and Palliative Care, Maloca Internationale, Third World Network and the Union for International Cancer Control. Issues included the following: access to opioids and palliative care; patenting and criminalization of traditional medicines; cancer treatment; use and standardization of essential medicine lists; acquisition, receipt, distribution and storage of medicines; impact of changing political regimes on

health systems: procurement of medicines and treatment of patients in resource-constrained settings; balancing between ensuring drug quality and safety and preventing overregulation and regulatory capture.

41. In his concluding remarks, Dr. Sengupta stated that, although safety was a valid and important concern, the current debate around it had political elements that could not be ignored. Decisions and policies affecting health care must not lose sight of the ultimate objective of fulfilling the people's right to health. Dr. Hayman agreed that safety, particularly for use of opiates, was an important concern. He emphasized the responsibilities of all governments in guaranteeing access to medicines. Mr. Borisov described how the transition from the Soviet public health system to the current public/private health system had had a negative impact on access to health care in the Russian Federation. Currently, thousands lacked adequate cancer care because of coverage gaps and insufficient financing for legislative mandates, exacerbated by lack of transparency in decision-making. Ms. Kamoga stated that substandard drugs posed a real challenge, particularly in Uganda which lacked appropriate regulatory and enforcement mechanisms. She advocated a rights-based approach to access to medicines that empowered communities and individuals and employed effective, evidence-based policies.

H. Breakout discussion groups and plenary discussion

42. All participants were invited to join one of three breakout discussion groups. Each focused on a key issue relating to access to medicines in the context of the right to health. Group one, facilitated by Dr. Velásquez, addressed intellectual property regimes and access to medicines. Group two, facilitated by Nhan T. Tran, Manager, Implementation Research Platform, Alliance for Health Policy and Systems Research, WHO, focused on health systems strengthening, capacity-building, community engagement and empowerment. Group three, facilitated by Dr. Sengupta, discussed financing access to medicines and universal health coverage. In those groups, participants focused on identifying concrete solutions and good practices for overcoming barriers to access to medicines.

43. During the plenary discussion which followed, the main findings of the groups were presented by a rapporteur nominated by each group. All participants were given an opportunity to respond and present proposals for the conclusions and recommendations of the Social Forum. Those who took the floor were representatives of Ecuador, Panama, Ariel Foundation International, Knowledge Ecology International, Third World Network and Universities Allied for Essential Medicines, as well as Ms. Forman, Dr. Meguid, Dr. Sengupta and Damiano de Felice, Strategic Adviser to the Chief Executive Officer, Access to Medicine Foundation. A synthesis of the proposals emerging from the breakout and plenary discussions is reflected in the conclusions and recommendations of the present report.

I. Innovative approaches to promoting access to medicines

44. Geoff Adlide, Director of Advocacy and Public Policy at Gavi, the Vaccine Alliance, explained the innovative efforts of Gavi to shape vaccine markets with a view to promoting access. Gavi was a public-private partnership focused on saving children's lives and promoting human health through improved access to immunization in poor countries. It sought to address inequities in access to vaccines through innovative approaches to access, governance, monitoring and vaccine markets. It supported vaccine purchases by low-income countries through pooling domestic and regional purchasing power and donor contributions to minimize costs. Gavi also promoted competition and sought to balance supply and demand to ensure continuous supplies of the vaccines required. It tried to

improve vaccination delivery including with regard to thermostability, presentation and packaging, combinations, safety and efficiency. Timely, transparent and accurate market information for manufacturers and States was essential to its work to promote sustainable access to vaccines for all.

45. Nana Boohene, Procurement and Supply Specialist, Global Fund to Fight AIDS, Tuberculosis and Malaria, and Hye-Young Lim, Human Rights Adviser at the Global Fund, presented the Fund's work to promote access to medicines. A rapidly evolving global health landscape required innovative approaches to increasing access to essential health commodities. The Global Fund operated in 140 countries and adaptability was integral to maximizing its impact. When States reached middle-income status, they lost access to certain benefits in international assistance and delayed implementation of TRIPs which had an impact on their ability to procure medicines. The Fund sought to improve access by underserved populations worldwide by reducing market fragmentation to capitalize on collective negotiating power including through the use of electronic marketplaces and exchanges. Its strategies directly integrated human rights considerations, focused on procurement for impact, leveraged new technologies for innovation and supply chain management, and promoted market access and continuity of supply. The Fund sought to increase investment in programmes that addressed human rights barriers to accessing health services and withdraw support from programmes that infringed upon human rights.

46. Rohit Malpani, Access to Medicines Campaign Director of Policy and Analysis, Médecins Sans Frontières, described the Access Campaign, which responded to doctors' frustration regarding the availability, affordability and suitability of medicines. It sought to address basic market failures of the patent system, under which research and development costs were to be recouped through monopolies leading to high-priced products. There was no incentive for research and development for the poor nor for expanding their access. The Campaign called for delinking product prices from research and development costs. Its 3P project, "push, pull, pool", aimed to combine push funding, pull funding and the pooling of intellectual property rights to promote innovative research and development for new, effective tuberculosis drug regimens and affordable access to quality medicines for all. In multidrug-resistant tuberculosis, the 3P project incentivized collaborative, early-stage research through patent pooling and pull and push funding. By securing public funding for prizes and clinical trials, ensuring an open and collaborative model, it promoted the collaborative development of drug regimens through patent pooling. The Campaign was seeking to promote a model of research and development that delinked its cost from the final product price and ensured that research and development for tuberculosis was carried out in a manner that delivered effective, short-course, affordable tuberculosis regimens for all.

47. Lena Kähler, Researcher, Human Rights and Development, Danish Institute for Human Rights, a national human rights institution mandated to promote and protect human rights in Denmark and abroad, introduced the Institute's efforts to develop indicators for accessibility, availability, acceptability and quality in the context of the right to health. The lack of consensus on the interpretation of economic, social and cultural rights constituted an obstacle to its work. By developing a generally applicable toolbox on right to health indicators, it hoped to promote realization of the right to health locally and globally. The Institute had identified as core obligations the availability of essential medicines, prevention, treatment and control of epidemic and endemic diseases, immunization against major infectious diseases, and reproductive, maternal and child health care.

48. During the discussion, there were interventions from representatives of Brazil, Chile, the China Medical Association, the Colombian Commission of Jurists, Third World Network, Universities Allied for Essential Medicines, as well as from Dr. Sengupta, Dr. Mohamed and Dr. Meguid. Some speakers described efforts to impede production of

low-cost generic pharmaceuticals as crimes against humanity. Others called on the Human Rights Council and special procedures mandate holders to focus on access to medicines. They supported a holistic, people-centred and community-driven approach to health. That would include innovative efforts to address neglected diseases, like multiple drug-resistant tuberculosis, that disproportionately impacted on the poorest and most vulnerable, and to promote improved governance mechanisms, particularly for regulatory oversight and accountability of multinational corporations. The question was raised as to whether or not efforts to promote access had gone far enough to seek alternatives to market-based approaches.

49. In their concluding remarks, the panellists supported further integration of human rights considerations in access to medicines. Ms. Lim stressed the need to integrate human rights principles throughout procurement processes. She noted that the concept of middle-income countries was an artificial one and that access to medicines should not be dictated by the economic status of a country but by the needs of people, and that the Global Fund to Fight AIDS, Tuberculosis and Malaria was supporting the strengthening of health systems in a number of countries. Citing the work of the Committee on Economic, Social and Cultural Rights, Ms. Kähler asserted that the right to health required access to all medicines not only essential medicines. Mr. Adlide clarified that Gavi only supplied vaccinations through governments; responded to requests from governments; worked to reduce prices and emphasized transparency in its operations. Mr. Malpani decried continued mispricing of vaccines, called for rendering access to medicines sustainable and reiterated that middle-income countries faced substantial challenges in improving access.

J. Good practices in promoting access to medicines (round table)

50. Mr. de Felice described the Access to Medicine Index, a ranking of the world's 20 largest research-based pharmaceutical companies on the basis of what they did to facilitate access to medicine in developing countries. He noted that there was hope, that there were good practices, and that the Index, by drawing attention to corporate behaviour, could influence businesses to exercise greater responsibility. The Index compared corporations on the basis of their performance over time with regard to multiple factors, including but not confined to governance, pricing, patents, local stakeholder engagement, capacity-building and donations. Although progress was uneven, the Index indicated that the pharmaceutical industry had stepped up its efforts to improve access to medicine in developing countries. A competitive environment that not only held pharmaceutical companies accountable when required, but also recognized their efforts and accomplishments, would help advance access to medicines.

51. Sathyanarayanan Doraiswamy, Senior Reproductive Health/HIV Coordinator, Office of the United Nations High Commissioner for Refugees (UNHCR), described UNHCR work to ensure access for refugees and other persons of concern. When people were forcibly displaced across national borders, they became refugees, often with limited access to health care in countries of asylum. UNHCR efforts to promote health care for refugees were guided by its global strategy for public health and its guidelines on essential medicines and medical supplies. Those addressed the needs of persons in differing phases and contexts including acute emergencies, protracted displacement and in their pursuit for durable solutions. The two main models for providing health care were direct integration in national systems of host States and integration to the maximum extent possible combined with support from UNHCR and non-governmental organizations. UNHCR pursued various methods to promote access, including: provision of emergency health kits, collaboration with national AIDS programmes to support antiretroviral treatment, research programmes

and partnerships with the private sector. While those provided short-term solutions, the only long-term sustainable solution was total integration into national health systems.

52. Soraya Ramoul, Director, Access to Health, Novo Nordisk, described the company's efforts to promote access to medicines for the treatment of diabetes. Many people with diabetes resided in low and middle-income countries. Novo Nordisk provided half of the insulin worldwide. It employed differential pricing policies so that patients in developing countries paid one quarter of the price paid in developed countries. However, access was not simply a matter of affordability. It also required strong health delivery systems including sufficient and adequately trained medical personnel. Local prices might differ from initial purchasing prices because of supply chain problems, price mark-ups, import duties and taxes. Further efforts were needed to ensure that prices offered to patients were affordable and also sustainable from a business perspective. Better implementation of the right to health in the private sector context required translation of technical human rights language into business language.

53. James Love, Director, Knowledge Ecology International, recommended drastic changes to existing models of research and development and intellectual property rights. The prevailing system had failed to promote access and was fundamentally unfair. It created patent monopolies, vesting power and profits in private hands. Corporate lobbying to protect those interests contributed to regulatory arbitrage and perpetuation of the status quo. That system valued profits over human well-being and failed to achieve its stated objective of promoting innovation, particularly in research and development for treatment of diseases that disproportionately impacted the poor and the vulnerable. He argued for changes to the intellectual property regime, improved incentives for underfunded areas of research and development, mobilization of innovative sources of finance, increased scrutiny by the Human Rights Council, particularly in applying the right to development in relation to intellectual property rights, and innovative approaches to research and development. Mr. Love advocated deep, radical and transformative reforms that would delink research and development costs from product prices along with the elimination of product monopolies, in favour of other financing mechanisms, including combination of research grants, contracts and other subsidies and delinked financial incentives, including robust funding of large innovation inducement prizes for HIV/AIDS and cancer as well.

54. Esteban Burrone, Head of Policy, Medicines Patent Pool, described the evolution and work of that initiative. WHO first proposed the idea of a patent pool in 2008 as part of its global strategy on public health and innovation. After a feasibility study by the International Drug Purchase Facility (UNITAID) ("Innovative financing to shape markets for HIV/AIDS, malaria and tuberculosis"), which was welcomed by the Human Rights Council at its fifteenth session, the Medicines Patent Pool was set up to promote access to medicines for HIV treatment through resource pooling and voluntary licensing. Since 2010, that entity had negotiated licences for 11 antiretrovirals with five patent-holders. It worked with 10 generic manufacturers through 53 sublicensing agreements to improve access to antiretrovirals in low and middle-income countries where up to 94 per cent of people living with HIV resided. Patent pool licences had been recognized for their public health orientation, transparency and flexibility. Within four and a half years, the Pool had contributed to opening up the market for first and second line antiretrovirals. It was exploring expansion to cover tuberculosis and hepatitis C.

55. Smiljka de Lussigny, HIV Programme Manager, UNITAID, discussed that initiative's focus on innovative access to medicines. UNITAID used innovative financing, a major portion of which came from a levy on air tickets, for greater access to treatments and diagnostics for HIV, malaria and tuberculosis in low-income countries. It focused on maximizing available resources for the promotion of access by mobilizing resources and promoting their effective use. Affordability posed a substantial barrier to access,

particularly when States lacked appropriate national policies, access to affordable and quality generic medicines and/or financial resources. New, effective treatment for hepatitis C was largely inaccessible to many patients owing to prohibitive costs. UNITAID intervened by providing funding to organizations working to demonstrate the impact, cost-effectiveness and utility of new treatment and diagnostic tools and to develop the evidence needed to inform health policy and normative guidance. It also helped to improve the affordability of new commodities, often by leveraging its purchasing power to negotiate with manufacturers for the supply of quality-assured health products at lower prices or by enabling generic, low-cost production of medicines.

56. Hans Rietveld, Director, Market Access and Capacity-Building, Malaria Initiative, Novartis Pharma AG, introduced the Novartis Malaria Initiative. The latter had been involved in providing low-cost, life-saving treatment for malaria patients, a disease which had been taking the life of one child every 60 seconds for the past 15 years. It pursued multiple strategies to combat malaria including research and development of new treatment options, capacity-building, improving access and provision of treatment. Since 2001, the Initiative had delivered more than 700 million treatments without profit to 65 malaria endemic countries. It had developed paediatric tablets that were dissolvable in liquid for babies and children and an improved formulation for adults. The Power of One campaign treated one child for every dollar raised. Its partnership with the fund-raising organization Malaria No More had rallied public support and funds for 3 million malaria treatments in Zambia. The Initiative sought simple and innovative solutions to complex problems. For example, it had utilized mobile phones to monitor drug supplies in Africa and head off stock-outs, and published and distributed education materials on malaria prevention and treatment. However, much remained to be done including on development of new treatment for drug-resistant malaria and on strengthening health systems.

57. During the interactive dialogue, the following took the floor: representatives of Brazil, Indonesia, the International Association for Hospice and Palliative Care, New Generation Ishaka, Safe Observer International, Rencontre Africaine pour la défense des droits de l'homme, Third World Network, Universities Allied for Essential Medicines; Drs. Sengupta, Bermudez, Schiavon and Zhang; Ms. Forman. Many speakers called for a rights-based health paradigm to replace market-oriented solutions, and related actions from the Human Rights Council. They recommended increasing attention to the medical needs of children, corporate responsibility, equitable access to medicines, and reduction of regulatory barriers to access, including TRIPs and TRIPs-plus provisions, research and development of treatments for neglected tropical diseases, access to pain medication, and the use of tariffs to safeguard local manufacturing capacity. Several speakers called on States to promote access without discrimination, to put people first, and to refrain from exerting political pressure to increase patent protections at the expense of access to medicines. They called on the Secretariat to issue strong recommendations on intellectual property rights, regulatory measures, and equal access to health care and sexual and reproductive health. Reiterating that access to medicines was a matter of life and death, they demanded that States and the private sector take immediate action to remove barriers to access to medicines.

58. In response, Mr. Rietveld clarified that he spoke for the Novartis Malaria Initiative, and not Novartis as a whole. The Initiative worked because the non-profit business model and the scale of the problem had allowed Novartis and partners to combine their approaches into a sustainable effort to promote access to life-saving medicines. Ms. Ramoul urged governments, health-care professionals, activists and industry to avoid finger-pointing and instead collaborate to promote access to medicines. Mr. de Felice explained the methodology of the Access to Medicine Index and suggested additional research into neglected tropical diseases. He supported initiatives to promote sharing and enhanced access to intellectual property like the Medicines Patent Pool. Citing positive impacts of the

Patent Pool. Mr. Burrone appealed for greater risk-taking and policy experimentation. He highlighted the need to maintain drug quality while regulatory barriers were rationalized to promote access. Mr. Love lamented a system which excluded the majority, and the lack of access to cancer medication. He proposed fundamental changes to promote innovation in the least harmful manner, and to delink drug prices from research and development costs. Ms. de Tussigny referred to the obligation to promote access and use limited resources to benefit as many people as possible. She recommended addressing the issue of regulatory barriers to the importation of life-saving medicines and emphasized the important role of generic competition in reducing prices. Dr. Doraiswamy supported a greater focus on neglected populations and their rights.

IV. Conclusions and recommendations

59. In closing the Social Forum, the Chairperson assured all the participants of the continued commitment of Qatar to global health. He informed them of the World Innovation Summit for Health which had held its annual session in Qatar in February 2015. The Summit had brought together health leaders from over 80 countries to share the latest research, ideas and health innovations that had the potential to revolutionize the future of global health care.

A. Conclusions

60. Several common themes emerged from the 2015 Social Forum. Not only is access to medicines a matter of life and death; it also enhances the quality of life; and it is key to a life with dignity. Yet, 2 billion men, women and children have no access to essential medicines. Intellectual property laws, lack of finances, weak health systems, poverty, inequality and discrimination, among other factors, contribute to lack of access to medicines.

61. Access to medicines involves public health, social justice and international human rights obligations. The International Covenant on Economic, Social and Cultural Rights requires States to take steps, to the maximum of their available resources, to progressively realize the right to health, prohibit retrogressive measures and requires them to immediately fulfil their minimum core obligations. It also calls for international cooperation. Access to medicines is a core obligation. Medicines must be affordable, acceptable, accessible, of good quality, and made available without discrimination.

62. Access to medicines is a complex and multidimensional issue calling for holistic solutions. Measures must be put in place to improve supply chains, address the underlying social determinants of health, promote policy coherence premised on the primacy of human rights over international trade, investment and intellectual property regimes and to ensure that health delivery systems are appropriate to those they serve. Inequities must be eliminated, including high costs borne by patients in many low and middle-income countries.

63. People's agency and empowerment should be improved to enhance access to medicines especially for the poor. Procedural safeguards like participation and access to information must be upheld. Evidence-based guidelines and policies to promote access to appropriate health-care services for women would help realize their right to health, and an increase in paediatric formulations would strengthen access for children. Addressing stigma and discrimination and ensuring equitable access and effective treatment would help realize the rights of people living with HIV.

64. Resource constraints cannot be an excuse for failing to meet health needs. Reasons for disparities in health outcomes across States of similar socioeconomic status must be understood and addressed. Experience shows that publicly funded health systems are the best way to ensure equitable access to health care. Access can be improved through innovative financing mechanisms; enabling public policies; more health workers; technical support; better health data, administrators, transport and delivery; improved supply chains, local production and health education; and other means. Holistic, people-centred and community-driven policies and active local involvement help strengthen health systems.

65. Access to medicines is one of the most explicit examples of how economics and trade rules conflict with human rights, including the rights to life, health and development. All are entitled to enjoy the benefits of scientific progress and traditional knowledge must be protected. Pharmaceutical companies must comply with their human rights responsibilities and ethical obligations. Several initiatives and good practices, including by those companies, point to steps in that direction. New models of research and development must address needs, not simply manage markets and profits.

66. Effective health policies, including the development of essential medicines lists, could improve access. States must live up to their individual and collective commitments and adopt a human rights-based approach to access to all medicines, not only essential medicines. International solidarity and collective action could support access for all.

B. Recommendations

67. Participants recommended urgent and immediate action, at the local, national, regional and international levels. Health systems needed to be strengthened, universal health coverage established and access to medicines ensured. That included building production capacity in developing countries, allowing access to generic drugs, enhancing research and development into treatment for neglected diseases and implementing effective procurement, distribution, price and quality control systems. Urgent steps to improve access to maternal and child health would help prevent maternal and infant mortality. The international community must aim for universal access in the post-2015 development agenda, which should also include mental health.

68. All stakeholders should explore ways of mobilizing new and innovative means of financing development and increasing resources available for health. Possibilities included imposition of a financial transaction tax, debt cancellation, resource pooling and tax reforms. International financial institutions must allow States sufficient policy space to pursue health objectives and States should make efforts to utilize existing resources more effectively including by leveraging their political and purchasing power to negotiate reduced prices and voluntary licensing.

69. TRIPS flexibilities and compulsory licensing should be used to their fullest and resort to political pressure to undermine those tools or impose TRIPS-plus provisions in trade agreements must be regarded as a violation of human rights obligations, calling for accountability in the universal periodic review. The legally binding petitions procedure under the Optional Protocol to the Convention on Economic, Social and Cultural Rights provided a means for interpretation and enforcement of the right to health.

70. Intellectual property laws required transformative changes to ensure that the benefits of scientific progress were enjoyed by all. Recommendations included

alternatives to market-based approaches and reforms to delink research and development costs from product prices. The recommendations of the report of the Global Commission on HIV and the Law, particularly the call for the United Nations to establish a commission to examine and propose alternatives to TRIPS, needed follow-up action. In the meantime, implementing TRIPS must be suspended, where it impeded access to medicines for the poor.

71. Participants called for a new and legally binding treaty on research and development of medicines that would promote innovation and equitable access. University research should be perceived as public research for everyone's benefit and not patented without proper safeguards to ensure access to resulting medicines. The Committee on Economic, Social and Cultural Rights should consider adopting a general comment on the right to enjoy the benefits of scientific progress.

72. All stakeholders should collaborate to enhance health systems. Participants proposed a holistic approach to health systems that enhanced equitable access, improved training of health and administrative personnel, employed culturally appropriate delivery systems, involved engagement with local communities and provided health and education outreach.

73. Participants recommended improved governance mechanisms, particularly for the regulatory oversight and accountability of multinational corporations. Pharmaceutical companies had responsibilities as articulated in the 2008 report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health (A/63/263) containing the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines. States, pharmaceutical companies, the Working Group on the issue of human rights and transnational corporations and other business enterprises, and the Human Rights Council should act to ensure their implementation.

74. The Human Rights Council and the international human rights machinery must remain seized of the issue. Participants recommended integration of a universal periodic review of the right to health and access to medicines that is evidence-based and promotes transparency and accountability. They called on the Council to commission a compilation of good practices in promoting access to medicines. The recommendations of the Social Forum must be taken up by the Council and acted upon.

Annexes

[*English only*]

Annex I

Provisional agenda

1. Opening of the session.
2. Implementation of Human Rights Council resolution 26/28 entitled "The Social Forum" on the theme "Access to medicines in the context of the right of everyone to the enjoyment of the highest standard of physical and mental health, including best practices in this regard".
3. Closure of the session.

Annex II

List of participants

States Members of the Human Rights Council

Argentina, Bolivia (Plurinational State of), Botswana, Brazil, China, Congo, Cuba, El Salvador, Ethiopia, France, Germany, India, Indonesia, Ireland, Japan, Kenya, Mexico, Morocco, Pakistan, Qatar, South Africa, United Kingdom of Great Britain and Northern Ireland, United States of America, Venezuela (Bolivarian Republic of).

States Members of the United Nations represented by observers

Angola, Australia, Austria, Bahrain, Belarus, Belgium, Chile, Colombia, Ecuador, Greece, Honduras, Iran, Italy, Kuwait, Lao People's Democratic Republic, Lebanon, Lithuania, Luxembourg, Mozambique, Myanmar, Nicaragua, Panama, Peru, Philippines, Senegal, Slovenia, Spain, Sri Lanka, Switzerland, Syrian Arab Republic, Tajikistan, Tanzania, Thailand, Togo, Tunisia, Ukraine, Zambia.

Non-Member States represented by observers

Holy See.

Intergovernmental organizations

Commonwealth Secretariat, Council of Europe, Global Fund to Fight AIDS, Tuberculosis and Malaria, Medicines Patent Pool, Organisation International de la Francophonie, South Centre, UNITAID (Innovative Financing to Shape Markets for HIV/AIDS, Malaria and Tuberculosis), World Trade Organization.

United Nations

United Nations Conference on Trade and Development, United Nations Educational, Scientific and Cultural Organization, United Nations Development Programme.

Specialized agencies and related organizations

Joint United Nations Programme on HIV/AIDS, United Nations High Commissioner for Refugees, World Health Organization.

Non-governmental organizations

Access Our Medicine Initiative, AIDS Free World, Alliance Defending Freedom International, American Association of Jurists, Ariel Foundation International, Asian-Eurasian Human Rights Forum, Asia Pacific Network of People Living with HIV/AIDS, Association of World Citizens, Associazione Comunita Papa Giovanni XXIII, Autistic Minority International, Caritas Internationalis, Center for Reproductive Rights, Centre du

Commerce International pour le Développement, China Medical Association, Civicus, Commission Africaine des Promoteurs de la Santé et des Droits de l'Homme, Community Health and Information Network Uganda, Comision Colombiana de Juristas, Déclaration de Berne, Dominicans for Justice and Peace, Dr. Hawa Abdi Foundation, Equal Right to Life, Gavi, The Vaccine Alliance, Geneva for Human Rights, Health Innovation in Practice, HealthNet TPO, Hope International, Indian Council of South America, International Association for Hospice and Palliative Care, International Investment Center, International Longevity Centre/NGO Committee on Ageing, International Network for the Prevention of Elder Abuse, Intellectual Property Watch, Ipas Mexico, International Treatment Preparedness Coalition, International Youth and Student Movement for the United Nations, Jingguo Law Firm, Knowledge Ecology International, La Compagnie des Filles de la Charité de Saint Vincent de Paul, LDS Charities, Médecins Sans Frontières, Maloca Internationale, Mylan, India, New Generation Ishaka Belgium, Organisation of Islamic Cooperation, People's Health Movement, Press Trust of India, Rencontre Africaine pour la défense des droits de l'homme, Safe Observer International, Salud Por Derecho, Save the Children International, Sparkwater India, Third World Network, Union for International Cancer Control, Universities Allied for Essential Medicines, World Federation of the Society of Anaesthesiologists, Zomi Community USA.

National human rights institutions

The Danish Institute for Human Rights.

National Ministries and Departments

Department of Health, South Africa; Inala Indigenous Health Service, Australia; Ministry of Health, Brazil.

Academic institutions

Peking University, State University of Zanzibar, University of Strasbourg, University of Toronto, Vilnius University, Sichuan University.

Private sector

Access to Medicine Foundation, Malaria Initiative, Novartis Pharma AG, Novo Nordisk.

Independent experts

Dainius Pūras, United Nations Special Rapporteur on the Right to Health.